Category A – AFSCME, Non-Represented Employees, & Elected Officials

MEDICAL BENEFITS COMPARISON SPREADSHEET

Effective Date: September 1, 2014

REMINDER: This is a general outline of medical benefits and not a guarantee of coverage or service. The information is presented in summary form and should be used for general comparison purposes only. Consult with either Regence or Group Health with specific questions. Provisions of the plan that are calculated on a calendar year basis are deductibles and Out of Pocket Maximums. Each January 1, those calendar year maximums begin again.

Regence Plan A Group # 10008695	**Regence Plan B** Group # 10008695	**Group Health Alliant Plus** Group #5910400
PLAN DESCRIPTION The Regence Preferred Plan offers a wide choice of health care providers who have agreed to accept negotiated fees for their services to you, as well as providers who are not contracted with Regence BlueShield. Preferred Providers (PPO) are Category 1 and are paid at the highest level. Participating Providers (Par) are Category 2 and are paid at the second level of benefits. Category 3 Providers (Non Par) are not contracted and are also in the second level of benefits. Co-pays are waived for Category 3, as there may be balance billing. **Regence Plan A does not require you to choose a Primary Care Provider (PCP) or to seek referrals for most services. Fees in addition to the deductible and coinsurance will be applied to specific imaging studies, inpatient surgery, and outpatient surgery. Plan A offers an enriched benefit for certain chronic conditions. Some treatments for depression, asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) and diabetes are covered at 100% with a waived deductible when using a Category 1 provider. Specifically: eye exams for diabetes; spirometry for diagnosis of COPD and asthma; specific outpatient labs/imaging for asthma, COPD, CHF, CAD, and diabetes. Additionally, some generic medications for asthma, diabetes, CAD, COPD, CHF, and depression have no co-pay. Some brand formulary insulin and diabetic supplies also have no co-pay.**	**PLAN DESCRIPTION** The Regence Preferred Plan offers a wide choice of health care providers who have agreed to accept negotiated fees for their services to you, as well as providers who are not contracted with Regence BlueShield. Preferred Providers (PPO) are Category 1 and are paid at the highest level. Participating Providers (Par) are Category 2 and are paid at the second level of benefits. Category 3 Providers (Non Par) are not contracted and are also in the second level of benefits. Co-pays are waived for Category 3, as there may be balance billing. **Plan B does not require you to choose a Primary Care Provider (PCP) or to seek referrals for most services. Fees in addition to the deductible and coinsurance will be applied to specific imaging studies, inpatient surgery, and outpatient surgery.**	**PLAN DESCRIPTION** The Group Health Alliant Plus Plan provides comprehensive health care services. To receive in-network benefits, participants must select a clinic and/or a Primary Care Provider (PCP) from the provider list. Providers include Group Health doctors at Group Health medical centers, Group Health contracted providers in the community, Virginia Mason and Everett Clinic medical centers, plus out-of-network coverage. Referrals are necessary for some services. Please consult your PCP or Group Health Member Services for more information.

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PLAN INFORMATION www.wa.regence.com Customer Service Number: 1-866-219-4116	**PLAN INFORMATION** www.wa.regence.com Customer Service Number: 1-866-219-4116	**PLAN INFORMATION** www.ghc.org Customer Service Number: 1- 888-901-4636
PHYSICIANS **Category 1 & 2 (PPO and Par)**: You will not be billed for balances beyond any deductible, co-payment, and/or co-insurance for covered services **Category 3 (Non Par)**: You may be billed for balances beyond any deductible and/or co-insurance	**PHYSICIANS** **Category 1 & 2 (PPO and Par)**: You will not be billed for balances beyond any deductible, co-payment, and/or co-insurance for covered services **Category 3 (Non Par)**: You may be billed for balances beyond any deductible and/or co-insurance	**PHYSICIANS** You may choose a primary care provider at Group Health medical centers, Group Health contracted providers, The Everett Clinic, or Virginia Mason. You can also use any outside network physician at the out of network benefit level; see **EXTENDED/OUTSIDE NETWORK BENEFITS**
ALTERNATIVE HEALTH CARE PROVIDERS Naturopaths covered same as physician services. Massage therapy incorporated in existing rehabilitation benefits for physical therapy treatment. Massage treatments at a spa are not a covered benefit. Acupuncture covered 12 visits per year. If for chemical dependency, covered the same as chemical dependency benefits. Not covered for smoking cessation.	**ALTERNATIVE HEALTH CARE PROVIDERS** Naturopaths covered same as physician services. Massage therapy incorporated in existing rehabilitation benefits for physical therapy treatment. Massage treatments at a spa are not a covered benefit. Acupuncture covered 12 visits per year. If for chemical dependency, covered the same as chemical dependency benefits. Not covered for smoking cessation.	**ALTERNATIVE HEALTH CARE PROVIDERS** **Inside Network**: Subject to co-pay **Outside Network:** $20 co-pay, deductible and co-insurance apply. Self-referral to contracted naturopathic providers for 3 visits per condition, per calendar year. Self-referral to contracted acupuncturist for 8 visits per diagnosis, per calendar year.
EXTENDED/OUTSIDE NETWORK BENEFITS **Outside Service Area:** Benefits are the same regardless of your geographic location. To receive the highest benefit level, members must utilize the local Blue Cross/Blue Shield providers.	**EXTENDED/OUTSIDE NETWORK BENEFITS** **Outside Service Area:** Benefits are the same regardless of your geographic location. To receive the highest benefit level, members must utilize the local Blue Cross/Blue Shield providers.	**EXTENDED/OUTSIDE NETWORK BENEFITS** You may choose an outside network physician without a referral if you are willing to pay a greater share of the costs.
DEDUCTIBLE $300/person, $600/couple, $900/family (3+ people)	**DEDUCTIBLE** **PPO & Par Providers:** None **Non Par:** $200/person, $600/family	**DEDUCTIBLE** **Inside Network:** None **Outside Network:** $200/person, $300/family
OUT OF POCKET MAXIMUMS* $1,100/person, $2,500/family *Includes deductible*	**OUT OF POCKET MAXIMUMS** **PPO & Par:** $2,500/person, $7,500/family **Non Par:** $10,200/person, $30,600/family Includes deductible	**OUT OF POCKET MAXIMUMS** **Inside Network:** $1,000/member, $2,000/family **Outside Network:** $2,200/member, $4,300/family
PHYSICIAN OFFICE VISITS **PPO:** Covered at 90% after deductible **Par**: 70% after deductible **Non Par:** 70% after deductible	**PHYSICIAN OFFICE VISITS** **PPO:** $30 co-pay, covered at 100% **Par:** $30 co-pay, 70% **Non Par:** 70% after deductible	**PHYSICIAN OFFICE VISITS** **Inside Network**: $20 co-pay, covered at 100% **Outside Network:** $20 co-pay, 80% after deductible
INPATIENT HOSPITAL **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**INPATIENT HOSPITAL** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**INPATIENT HOSPITAL** **Inside Network:** Covered at 100% **Outside Network:** 80% after deductible

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OUTPATIENT HOSPITAL **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**OUTPATIENT HOSPITAL** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**OUTPATIENT HOSPITAL** **Inside Network**: $20 co-pay, covered at 100% **Outside Network:** $20 co-pay, 80% after deductible
SURGERY ANESTHESIA **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**SURGERY ANESTHESIA** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**SURGERY ANESTHESIA** **Inside Network:** Covered at 100% **Outside Network:** 80% after deductible
HOME HEALTH VISITS *Limited to 130 visits per year* Covered at 90% after deductible	**HOME HEALTH VISITS** *Limited to 130 visits per year* **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**HOME HEALTH VISITS** **Inside Network:** Covered within Options Network when prescribed as medically necessary by an Options Network Provider
HEARING EXAMS Not covered	**HEARING EXAMS** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**HEARING EXAMS** **Inside Network:** $20 co-pay, covered at 100% **Outside Network:** $20 co-pay, 80% after deductible
EYE EXAMS **Diabetic eye exams:** **PPO: Covered at 100%, deductible waived** **Par: & Non-Par: 70% after deductible** Regular eye exams: Not covered - Refer to **REGENCE VISION PLAN**	**EYE EXAMS** Not covered - Refer to **REGENCE VISION PLAN**	**EYE EXAMS** **Inside Network:** $20 co-pay, covered at 100% **Outside Network**: Not covered
PREVENTATIVE CARE EXAMS • Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings • Provider counseling for tobacco use cessation • Women's contraceptive methods, sterilization procedures, and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA • Certain services such as screening for gestational diabetes, breast feeding support, supplies and counseling. **PPO:** Covered at 100%, not subject to deductible **Par:** 100%, not subject to deductible **Non Par:** 70% after deductible	**PREVENTATIVE CARE EXAMS** • Preventive care services include routine well-baby care, routine physical examinations, routine well-women's care, routine immunizations and routine health screenings • Provider counseling for tobacco use cessation • Women's contraceptive methods, sterilization procedures, and patient education and counseling services in accordance with any frequency guidelines according to, and as recommended by HRSA • Certain services such as screening for gestational diabetes, breast feeding support, supplies and counseling. **PPO:** Covered at 100% **Par:** 100% **Non Par:** 70% after deductible	**PREVENTATIVE CARE EXAMS** Follows federal health reform guidelines. **Inside Network:** Covered at 100% **Outside Network:** 100%, not subject to deductible Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.

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WELL CHILDCARE See **PREVENTATIVE CARE EXAMS**	**WELL CHILDCARE** See **PREVENTATIVE CARE EXAMS**	**WELL CHILDCARE** See **PREVENTATIVE CARE EXAMS**
IMMUNIZATIONS See **PREVENTATIVE CARE EXAMS**	**IMMUNIZATIONS** See **PREVENTATIVE CARE EXAMS**	**IMMUNIZATIONS** See **PREVENTATIVE CARE EXAMS**
GYNECOLOGICAL EXAMS See **PREVENTATIVE CARE EXAMS**	**GYNECOLOGICAL EXAMS** See **PREVENTATIVE CARE EXAMS**	**GYNECOLOGICAL EXAMS** See **PREVENTATIVE CARE EXAMS**
HOSPITAL SERVICES (ROOM, BOARD, ETC) **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**HOSPITAL SERVICES (ROOM, BOARD, ETC)** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**HOSPITAL SERVICES (ROOM, BOARD, ETC)** **Inside Network:** Covered at 100% **Outside Network:** 80% after deductible
INTENSIVE CARE **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**INTENSIVE CARE** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**INTENSIVE CARE** **Inside Network:** Covered at 100% **Outside Network:** 80% after deductible
OUTPATIENT SURGERY **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible **The following inpatient and outpatient surgeries have a $300 co-pay in addition to co-insurance and deductible:** breast reduction for medically necessary purposes, eye lid surgery, varicose vein surgery, joint replacement surgeries (hips & knees), lumbar surgery for low back pain, nasal surgery (rhinoplasty, septoplasty, turbinates), podiatric surgery (hammer toes and bunions), transurethral resection of the prostate (TURP) and vasectomy. The co-pay is applied to the surgeon's bill.	**OUTPATIENT SURGERY** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible **The following inpatient and outpatient surgeries have a $300 co-pay in addition to co-insurance and deductible:** breast reduction for medically necessary purposes, eye lid surgery, varicose vein surgery, joint replacement surgeries (hips & knees), lumbar surgery for low back pain, nasal surgery (rhinoplasty, septoplasty, turbinates), podiatric surgery (hammer toes and bunions), transurethral resection of the prostate (TURP) and vasectomy.. The co-pay is applied to the surgeon's bill.	**OUTPATIENT SURGERY** **Inside Network:** $20 co-pay, covered at 100% **Outside Network:** $20 co-pay, 80% after deductible
EMERGENCY CARE ***$200 co-pay waived if admitted*** **PPO:** $200 co-pay, covered at 90% after deductible **Par**: $200 co-pay, 90% after deductible **Non Par:** $200 co-pay, 90% after deductible	**EMERGENCY CARE** ***$200 co-pay waived if admitted*** **PPO:** $200 co-pay, covered at 100% **Par:** $200 co-pay, 100% **Non Par:** $200 co-pay, 100% after deductible	**EMERGENCY CARE** ***$200 co-pay waived if admitted***

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OUT OF AREA BENEFITS **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**OUT OF AREA BENEFITS** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**OUT OF AREA BENEFITS** **Coverage worldwide for emergency:** $200 co-pay (waived if admitted), 80% after deductible
SKILLED NURSING *Limited to 90 days per year* **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**SKILLED NURSING** *Limited to 90 days per year* **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**SKILLED NURSING** **Inside Network:** Covered with pre-authorization by Options Network as a cost-saving alternative to acute care hospitalization for up to 60 days **Outside Network:** 80% after deductible for up to 60 days
AMBULANCE Covered at 80% after deductible, any recognized provider	**AMBULANCE** Covered at 80% after deductible, any recognized provider;	**AMBULANCE** **Inside Network:** Covered at 80%; Options Network initiated non-emergency transfers covered in full **Outside Network:** 80% after deductible
X-RAY/LAB **PPO:** Covered at 90% after deductible* **Non PPO:** 70% after deductible *Mammograms covered* ***LDL-C, HbA1C, urine microalbum labs covered at 100%, deductible waived for PPO** ***Spirometry testing covered for asthma and COPD at 100%, deductible waived for PPO** **The following imaging services have a $100 co-pay in addition to co-insurance/deductible:** Bone density study, Computer Tomography (CT) scan, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiogram (MRA), Position Emission Tomography (PET), & Single-Proton Emission Tomography (SPECT)	**X-RAY/LAB** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible *Mammograms covered* **The following imaging services have a $100 co-pay in addition to co-insurance/deductible:** Bone density study, Computer Tomography (CT) scan, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiogram (MRA), Position Emission Tomography (PET), & Single-Proton Emission Tomography (SPECT)	**X-RAY/LAB** **Inside Network:** Covered at 100% **Outside Network:** 80% after deductible *Mammograms covered*
RADIATION THERAPY **PPO:** Covered at 90% after deductible **Non PPO:** 70% after deductible	**RADIATION THERAPY** **PPO**: Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**RADIATION THERAPY** **Inside Network:** Covered at 100% inpatient; $20 co-pay outpatient **Outside Network:** 80% after deductible inpatient; $20 co-pay, 80% after deductible outpatient

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REHABILITATION THERAPY *Physician referral required* **Inpatient:** 32 days **Outpatient/PPO:** Covered at 90% after deductible **Par:** 70% to 55 visits per year after deductible **Non Par:** 70% to 55 visits per year after deductible	**REHABILITATION THERAPY** *Physician referral required* **Inpatient:** 32 days **Outpatient/PPO:** $30 co-pay, covered at 100% to 55 visits a year **Par:** $30 co-pay, 70% to 55 visits a year **Non Par:** 70% to 55 visits a year after deductible	**REHABILITATION THERAPY** **Inpatient:** Covered at 100% up to 60 days inside/outside network **Outpatient:** $20 co-pay up to 60 visits/condition **Outside Network:** 80% after deductible
NEURODEVELOPMENTAL (TO AGE 7) *Physician referral required* *Limited to 36 visits per year* **PPO:** Covered at 90% after deductible **Non PPO:** 70% after deductible	**NEURODEVELOPMENTAL (TO AGE 7)** *Physician referral required* *Limited to 36 visits per year* **PPO:** $30 co-pay, covered at 100% **Par:** $30 co-pay, 70% **Non Par:** 70% after deductible	**NEURODEVELOPMENTAL (TO AGE 7)** See **REHABILITATION THERAPY**
MENTAL HEALTH CARE **PPO:** Covered at 90% after deductible **Par:** 90% after deductible **Non Par:** 70% after deductible	**MENTAL HEALTH CARE** **PPO:** $30 co-pay, covered at 100% **Par:** $30 co-pay, covered at 100% **Non Par:** 70% after deductible	**MENTAL HEALTH CARE** **Inside Network:** **Inpatient:** Covered in full **Outpatient:** $20 co-pay, deductible applies **Outside Network:** **Inpatient:** Deductible and co-insurance applies **Outpatient:** $20 co-pay, deductible and co-insurance applies
TREATMENT OF CHEMICAL DEPENDENCY **PPO:** Covered at 90% after deductible **Par:** 90% after deductible **Non Par:** 70% after deductible	**TREATMENT OF CHEMICAL DEPENDENCY** **PPO:** Covered at 100% **Par:** 100% **Non Par:** 70% after deductible	**TREATMENT OF CHEMICAL DEPENDENCY** **Inside Network:** **Inpatient**: Covered in full **Outpatient:** $20 co-pay, deductible applies **Outside Network:** **Inpatient:** Deductible and co-insurance applies **Outpatient:** $20 co-pay, deductible and co-insurance applies
HOME HEALTH CARE *Limited to 130 visits per calendar year* Covered at 90% after deductible, any recognized provider	**HOME HEALTH CARE** *Limited to 130 visits per calendar year* **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**HOME HEALTH CARE** **Inside Network:** Covered at 100% with pre-authorization; no visit limit **Outside Network:** 80% after deductible; no visit limits
HOSPICE CARE *Limited to 14 respite days per lifetime* Covered at 90% after deductible, any recognized provider	**HOSPICE CARE** *Limited to 14 respite days per lifetime* **PPO:** Covered at 100% **Par**: 70% **Non Par:** 70% after deductible	**HOSPICE CARE** **Inside Network:** Covered at 100% when provided and coordinated through Options Network approved hospice program **Outside Network:** 80% after deductible

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SPINAL MANIPULATIONS *Limited to 10 spinal manipulations per calendar year by a chiropractor or osteopath* **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par**: 70% after deductible	**SPINAL MANIPULATIONS** *Limited to 10 spinal manipulations per calendar year by a chiropractor or osteopath* **PPO:** $30 co-pay, covered at 100% **Par:** $30 co-pay, 70% **Non Par:** 70% after deductible	**SPINAL MANIPULATIONS** **Inside Network:** $20 co-pay, covered at 100% to 10 visits per calendar year **Outside Network:** $20 co-pay, 80% up to 10 visits after deductible
PODIATRY **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible $300 co-pay in addition to co-insurance and deductible for Hammer Toe and bunion surgery	**PODIATRY** **PPO:** $30 co-pay, covered at 100% **Par:** $30 co-pay, 70% **Non Par:** 70% after deductible $300 co-pay in addition to co-insurance and deductible for Hammer Toe and bunion surgery	**PODIATRY** **Inside Network:** $20 co-pay; covered at 100% **Outside Network:** 80% after deductible; when medically necessary
MATERNITY Covered as any other condition Pregnancies of dependent daughters are covered *First 21 days of newborn care covered*	**MATERNITY** Covered as any other condition Pregnancies of dependent daughters are covered *First 21 days of newborn care covered*	**MATERNITY** **Inside Network:** Covered at 100%; prenatal/postpartum care is covered subject to $20 co-pay per outpatient visit **Outside Network:** 80% after deductible
CONTRACEPTIVE DEVICES AND DRUGS Covered at 100%	**CONTRACEPTIVE DEVICES AND DRUGS** Covered at 100%	**CONTRACEPTIVE DEVICES AND DRUGS** Covered at 100%
ELECTIVE STERILIZATION See **OUTPATIENT SURGERY**	**ELECTIVE STERILIZATION** See **OUTPATIENT SURGERY**	**ELECTIVE STERILIZATION** **Inside Network:** $20 co-pay, covered at 100% **Outside Network:** 80% after deductible Women's sterilization procedures are covered in full
DURABLE MEDICAL EQUIPMENT **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**DURABLE MEDICAL EQUIPMENT** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**DURABLE MEDICAL EQUIPMENT** **Inside Network:** Covered at 100% **Outside Network:** 100% after deductible
DURABLE MEDICAL SUPPLIES **PPO:** Covered at 80% after deductible **Par:** 80% after deductible **Non Par:** 80% after deductible	**DURABLE MEDICAL SUPPLIES** **PPO:** Covered at 80% **Par:** 80% **Non Par**: 80% after deductible	**DURABLE MEDICAL SUPPLIES** **Inside Network:** Covered at 100% **Outside Network:** 100% after deductible
TMJ **PPO:** Covered at 90% after deductible **Par:** 70% after deductible **Non Par:** 70% after deductible	**TMJ** **PPO:** Covered at 100% **Par:** 70% **Non Par:** 70% after deductible	**TMJ** **Inside Network:** **Inpatient:** Covered at 100% **Outpatient:** $20 co-pay **Outside Network:** **Inpatient:** 80% after deductible **Outpatient:** $20 co-pay, 80% after deductible

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TRANSPLANT **PPO**: Covered at 90% after deductible with no lifetime max; requires pre-authorization by plan and 12 month waiting period (time credit available) **Par:** 70% with no lifetime max; requires pre-authorization by plan and 12 month waiting period (time credit available) **Non Par:** 70% with no lifetime max; requires pre-authorization by plan and 12 month waiting period (time credit available)	**TRANSPLANT** **PPO:** Covered at 100% with no lifetime max; requires pre-authorization by plan and 12 month waiting period (time credit available) **Par:** 70% with no lifetime max; requires pre-authorization by plan and 12 month waiting period (time credit available) **Non Par:** 70% with no lifetime max; requires pre-authorization by plan and 12 month waiting period (time credit available)	**TRANSPLANT** No lifetime maximum; requires pre-authorization by plan; no waiting period Inside Network: Inpatient: Covered at 100% Outpatient: $20 co-pay Outside Network: Inpatient: 80% after deductible Outpatient: $20 co-pay, 80% after deductible
OUTPATIENT PRESCRIPTION DRUGS **30 day retail supply / 90 day mail order supply** $10 co-pay generic / $20 co-pay generic $20 brand formulary / $40 brand formulary $30 non formulary / $60 non formulary **Some generic medications for asthma, diabetes, coronary heart disease (CAD), chronic obstructive pulmonary disease (COPD), Coronary Heart Failure (CHF), and depression have no co-pay. Some brand formulary insulin and diabetic supplies also have no co-pay. Please see "Value Plus Medication List" for more information.**	**OUTPATIENT PRESCRIPTION DRUGS** **30 day retail supply / 90 day mail order supply** $10 co-pay generic / $20 co-pay generic $20 brand formulary / $40 brand formulary $30 non formulary / $60 non formulary	**OUTPATIENT PRESCRIPTION DRUGS** **Inside Network:** $15 co-pay up to 30 day supply; mail order $5 discount per 30 day supply **Outside Network:** you pay 20% generic cost unless brand name is medically necessary or $20 co-pay, whichever is greater; must use a Med-Impact pharmacy; mail order not available
MONTHLY RATES Employee Only: $5 Employee & Spouse/Partner: $20 Employee & Child(ren): $8 Employee & Family: $24	**MONTHLY RATES** Employee Only: $10 Employee & Spouse/Partner: $39 Employee & Child(ren): $17 Employee & Family: $46	**MONTHLY RATES** Employee Only: $0 Employee & Spouse/Partner: $0 Employee & Child(ren): $0 Employee & Family: $0

Rates apply to employees working 35+ hours per week. Employees working less than 35 hours per week will be offered benefits with pro-rated premiums.